

Practice Name:
Practice Address:

Paediatric Case History

(0 to 13 years of age)

All information contained in this questionnaire is strictly confidential.

Name:		Date of Birth:	
Address:			
Name/s of Parent/Guardians:			
Phone: (H)		(W)	(M)
Email Address:			
Siblings Names & Ages:			
Are you a member of a health fund that pays for Chiropractic Care? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know			
If Yes, please provide name of health fund:			
Who may we thank for referring you to our Practice? Googled It! / Other Internet Search / Yellow Pages / Newspaper / Friend or Family – Sign / Other -			
Has your child ever had Chiropractic Care before? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If Yes	Name of Chiropractor:		Located Where?
When was your child's last visit?		Reason for Care?	
What were the results of the treatment? Please ✓			
<input type="checkbox"/> Excellent	<input type="checkbox"/> Satisfactory	<input type="checkbox"/> Fair	<input type="checkbox"/> Did not help <input type="checkbox"/> Got worse
Did the Chiropractor take X-Rays? <input type="checkbox"/> Yes <input type="checkbox"/> No		Was your child examined thoroughly? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Is there a family history of Scoliosis or other Spinal problems? If so, please describe:			

Previous and Current Health

Name of Paediatrician:	Located where?
Date of last visit:	Reason for last visit:
Reason for your child's visit today:	
Has your child had any other serious health problems within the past 3 years? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If Yes, please describe what and when:	
Has your child ever been in a motor vehicle accident, had any sporting injuries or major falls? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Has your child ever been hospitalised or had any operations? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If Yes, please describe what and when:	
List any broken bones, fractures, dislocations or sprain injuries your child has had and when:	

Vaccination and Medicinal History

Has your child been vaccinated? <input type="checkbox"/> Yes <input type="checkbox"/> No	
How many doses of Antibiotics has your child taken: Past 6 months?	Total in his/her lifetime?
How many doses of Prescription Medications has your child taken: Past 6 months?	Total in his/her lifetime?
Please list medications:	
Is your child currently taking any type of medication, drugs or vitamins? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If Yes, Please ✓ <input type="checkbox"/> Antibiotics <input type="checkbox"/> Medication for any discomfort <input type="checkbox"/> Muscle relaxants <input type="checkbox"/> Anti-inflammatory <input type="checkbox"/> Vitamins <input type="checkbox"/> Anti-depressants <input type="checkbox"/> Other:	
For what condition/s is your child taking this medication?	

Prenatal History

Name of Obstetrician/Midwife:	
Complications during pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Ultrasounds during pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No How many:	
Medication during pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Cigarette/Alcohol use during pregnancy: <input type="checkbox"/> Yes <input type="checkbox"/> No Location of birth: <input type="checkbox"/> Home <input type="checkbox"/> Hospital <input type="checkbox"/> Birth Centre	
Type of birth: <input type="checkbox"/> Vaginal <input type="checkbox"/> C-Section <input type="checkbox"/> Planned induction <input type="checkbox"/> Emergency <input type="checkbox"/> Forceps <input type="checkbox"/> Suction/Vacuum Extraction	
<input type="checkbox"/> Normal <input type="checkbox"/> Breech <input type="checkbox"/> Posterior <input type="checkbox"/> At term <input type="checkbox"/> Premature <input type="checkbox"/> Overdue	
Any complications during surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Any Genetic disorders or disabilities? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Birth weight:	Birth length:
APGAR scores:	
Was your child's head mis-shapen at birth? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Feeding History

Breast fed: <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, for how long:	
Formula fed: <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, for	
Introduced to: Solids _____months Cows milk _____months	
Food/juice allergies or intolerances: <input type="checkbox"/> Yes <input type="checkbox"/> No	
If Yes, please describe:	

Has your child ever had any of the following?

<input type="checkbox"/> ADHD	<input type="checkbox"/> Chronic colds	<input type="checkbox"/> Eczema/Psoriasis	<input type="checkbox"/> Measles	<input type="checkbox"/> Recurring tonsillitis
<input type="checkbox"/> Allergies	<input type="checkbox"/> Colic/Reflux	<input type="checkbox"/> Falls head first from high places	<input type="checkbox"/> Mumps	<input type="checkbox"/> Scoliosis
<input type="checkbox"/> Appendicitis	<input type="checkbox"/> Constipation/Diarrhoea	<input type="checkbox"/> Growing/Back Discomfort	<input type="checkbox"/> Poor coordination	<input type="checkbox"/> Seizures/Epilepsy
<input type="checkbox"/> Asthma	<input type="checkbox"/> Developmental disorders	<input type="checkbox"/> Headaches	<input type="checkbox"/> Poor sleeping habits	<input type="checkbox"/> Social disorders
<input type="checkbox"/> Bed wetting	<input type="checkbox"/> Digestive problems	<input type="checkbox"/> Juvenile Diabetes	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Travel sickness
<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Ear infections	<input type="checkbox"/> Learning disorders	<input type="checkbox"/> Recurring fevers	<input type="checkbox"/> Whooping cough
Other:				

What are your child's habits

Has your child been in any of the following high impact or contact sports?	
<input type="checkbox"/> Soccer <input type="checkbox"/> Football <input type="checkbox"/> Gymnastics <input type="checkbox"/> Karate <input type="checkbox"/> Hockey <input type="checkbox"/> Basketball <input type="checkbox"/> Softball <input type="checkbox"/> Dance <input type="checkbox"/> Other	
According to the National Safety Council, approximately 50% of children fall head first from a high place during their first year of life.	
Was this the case for your child? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Had falls from: <input type="checkbox"/> Bed <input type="checkbox"/> Down stairs <input type="checkbox"/> Off swings <input type="checkbox"/> Change table <input type="checkbox"/> Out of trees <input type="checkbox"/> Off bike Total number of falls:	
During the following times your child's spine is most vulnerable to stress and should routinely be checked by a Doctor of Chiropractic for the prevention and early detection of vertebral subluxation (spinal nerve interference).	

Developmental History

At what age was your child able to:			
Respond to sound:	Respond to visual stimuli:	Hold head up:	Sit up alone:
Cross crawl:	Stand alone:	Walk alone:	
Posture is the window to the spine. Abnormal or bad posture contributes to spinal stress and may lead to vertebral subluxation. Vertebral subluxations can severely inhibit the ability of the Nervous System to function at its optimum.			
Does your child often slump or sit with rounded back and shoulders? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Does your child wear his/her backpack on both shoulders? <input type="checkbox"/> Yes <input type="checkbox"/> No			
How many hours per day does your child spend in front of the: Television: Computer:			
What position does your child sleep in at night? <input type="checkbox"/> Side <input type="checkbox"/> Back <input type="checkbox"/> Stomach <input type="checkbox"/> All			

PLEASE READ AND SIGN

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine for further evaluation and to take 'specific postural x-rays' if required.

Parent/Guardian's Signature:

Date: